Hamilton Niagara Haldimand Brant **LHIN**
RLISS de Hamilton Niagara Haldimand Brant

Improving Our Health Care Experience: Integrated Health Service Plan 2010-2013

December 2009

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

Give your health history
once

Imagine a health system

where you....

Have
easy to understand information
to help you make informed choices

Have
24 hour access
to a primary care provider

Have
one test
that is shared among your providers

Know your doctor receives
timely information
about you from others

Can make an appointment for a
visit to a clinician, a diagnostic
test or a treatment
with one phone call

Have a
wide choice
of primary care providers who can
give you the time you need

Get the right care
at the right place
at the right time

Acknowledgments

Many people, networks, and organizations have made contributions to the Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network (LHIN) Integrated Health Service Plan. Their conversations, deliberations and diligence have helped identify and shape strategies for improved health care. The LHIN thanks all those who have contributed to the planning processes and outcomes.

HNHB LHIN Voices

HNHB LHIN eHealth Strategic Plan (2006)
Project Management Office

Aging at Home for Healthy Aging (2007-2009)
Emergency Department and Alternate Level of Care Committees

Let's Talk: Aging at Home - Listening and Learning about Healthy Aging and Independent Living
LHIN residents

Soaring Vision: Aboriginal Health Search Conference (2008)
Health Opportunities for Aboriginal People (HOAP) Steering Committee

Diabetes Action Group Report (2008)
Chronic Disease Prevention and Management Steering Committee

Building Leadership Capacity - Governance to Governance Sessions (2008)
Boards of Health Service Providers

Clinical Services Plan (2009)
Clinical Planning Advisory Groups and Key Informants

French Language Health Services Community Workshop (2009)
Health Service Providers and Stakeholders

A Dialogue on Sustainable, Age Friendly Transportation - Summit (2008)
Transportation Survey (2009)
Transportation Providers and LHIN residents

Discover Learn Share - Open Houses (2009)
Community Residents

Every Door is the Right Door Survey (2009)
Residents living with mental health illnesses or addictions

Engaging Primary Care (2009)
Family Physicians, Nurse Practitioners, and Midwives

Table of Contents

Acknowledgments	i
Table of Contents	ii
Introduction	1
How the IHSP Aligns with Ministry Priorities	2
LHIN's Vision for the Local Health System	4
The Local Health Care System: A Snapshot	5
Framework for Planning	8
An Overview of Our Priorities	11
Alternate Care Settings	12
Emergency Department Capacity	14
Clinical Program Integration	16
Community Based Health Service Capacity	18
Aboriginal Health	20
Francophone Health	21
Chronic Disease Prevention & Management	22
Mental Health and Addictions	24
eHealth	26
Interprofessional Care	28
Transportation	30
Partners for Change	32
Rationale for Strategic Directions	34
Measuring Success	36
Commitment to Action	38
Supporting Documents	39
End Notes	39

Introduction

This second IHSP is a ***roadmap*** *for health system change for the next three years.*

In March 2006, the Ontario Government passed historic legislation, the *Local Health System Integration Act (LHSIA), 2006*, which has changed the way the health care system is managed. This signaled unprecedented local decision making for health care services in communities, by people who live and work in those communities.

The Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network (LHIN) is one of 14 LHINs established by the Ontario Government to plan, integrate, fund and monitor local health services[1]. These services include community support services, mental health and addictions services, and services provided by community health centres, the Community Care Access Centre (CCAC), long-term care homes and hospitals.

In 2006, the HNHB LHIN released its first Integrated Health Service Plan (IHSP). The Plan guided early priorities for health improvement and funding decisions over three years. This second IHSP is a road map for health system change for the next three years, 2010 - 2013.

This IHSP is informed by Ministry of Health and Long-Term Care (ministry) priorities for Ontario, and local priorities. It will guide the HNHB LHIN's annual business plans, integration priorities, and funding decisions for the local health system.

Open House, Eva Rothwell Resource Centre, Hamilton, October 20, 2009

How the IHSP Aligns with Ministry Priorities

LHINs and the ministry in Ontario are partners in planning improvements for health care and both have important roles. The ministry sets and shares its strategic vision and priorities. LHINs align with the ministry's directions and set additional priorities at the local level.

The HNHB LHIN's IHSP supports the ministry's priorities to promote equitable access to health and health care for all Ontarians and to improve access to care, reduce wait time in Emergency Departments (ED) and reduce wait time in hospital for alternate care (patient flow), and improve diabetes care (a chronic disease and prevention management priority).

The ministry has also identified mental health and addictions, and eHealth as key focus areas, both of which the HNHB LHIN supports through strategic priorities and activities.

Patient Flow

Improve access to Emergency Department (ED) care by reducing the number of non-urgent presentations to the ED, and reducing the amount of time that people spend waiting in the ED.

Ontarians are entitled to safe, reliable, appropriate and high-quality care when they visit an emergency department. Timely access to care can significantly improve a patient's experience which is why reducing emergency department wait times is one of Ontario's top health care priorities.

Experience tells us that a backlog in one area of the health system can result in delays in other areas. To achieve shorter emergency department wait times, LHIN's need to improve the efficiency of care delivery across the entire system. We also know that patients with non-urgent or less urgent needs account for about half of all emergency department visits; we need to look at ways to build capacity within the community so people can access appropriate care outside emergency departments. LHINs are working with health service providers to meet provincial targets, and all LHINs publicly report emergency department wait times.

Improve access to hospital care by reducing the amount of time that patients wait in hospital for alternate care when hospital care is complete.

Some patients who have completed the acute care phase of treatment in hospital, remain in acute care beds waiting to be discharged or transferred elsewhere. They need an alternate level of care which is not always available. Close to 19% of patients currently in Ontario hospital beds are waiting for an alternate setting such as their own home with supports, alternate housing, rehabilitation, palliative or convalescent care settings, or transfer to a long-term care home[2]. This often leads to longer wait times in the emergency department as patients wait to be admitted to an acute care hospital bed. The LHINs are working with the Ontario government on a variety of initiatives that will help patients get the care they need where they need it.

Diabetes Strategy for Chronic Disease Prevention and Management

Improve diabetes care and outcomes with a focus on prevention, early detection and self management.

Ontario's Diabetes Strategy is tackling a growing and expensive health care challenge. In 2008, about 900,000 Ontarians were living with diabetes (8.8% of the province's population)[3]. This number has increased by more than half over the last 10 years, and is projected to grow to 1.2 million people by 2010. Treatment for diabetes and related conditions (including heart disease, stroke and kidney disease) currently cost Ontario over $5 billion each year[4].

Chronic health conditions develop slowly over time, and are long lasting, yet many chronic conditions can be prevented and/or delayed, and risk factors for developing chronic conditions are modifiable.

The provincial Diabetes Strategy will improve access to prevention programs and team-based care. The Strategy includes an online diabetes registry; this is an electronic information, diagnostic, and educational tool that will enable health care providers to support people living with diabetes. The registry will include best practice guidelines, alert clinicians of the need for recurring diagnostic tests, and will give people access to information and educational tools to help them better manage their diabetes. The LHINs are committed to improving access to diabetes care by supporting the roll-out of the provincial Diabetes Strategy.

Mental Health and Addictions

Improve mental health well being and reduce substance use with a focus on early detection, prevention and access to services and supports.

About one in five Ontarians will experience a serious mental illness or harmful substance use at some time in their lives[5]. People of all ages are effected, and the cost of preventing and treating mental illnesses and addictions is only a fraction of what these illnesses cost society in lost productivity and other social costs. Investing in actively supporting people to stay mentally healthy saves money. Every $1 spent on mental health and addictions treatment and services saves $7 in health costs and $30 in lost productivity and social costs[6].

The Minister's Advisory Group on Mental Health and Addictions is developing a ten-year strategy to address this important issue. Most promising is that the strategy looks beyond health to include the roles and contributions of other sectors (for example housing, employment, education) for well-being. The LHINs will implement the provincial mental health and addictions strategy, helping to create a system that provides people equitable access to safe, respectful and effective services.

Building on an eHealth Framework

In March 2009, the Ontario government released a provincial eHealth strategy, which focuses on diabetes management, medication management, and wait times[7]. Through information technology (IT) investments such as the diabetes registry and electronic health records, the ministry aims to improve access to information and support the delivery of high quality health care to people across the province. The HNHB LHIN has several initiatives in place or underway, many in partnership with the Waterloo-Wellington LHIN. These are available on our website at www.hnhblhin.on.ca.

Imagine: A Healthier Ontario

The Ontario Government's strategic directions helped to shape this Integrated Health Service Plan. By aligning local initiatives with provincial priorities, the residents of the LHIN can receive appropriate, coordinated, safe and efficient health services.

LHIN's Vision for the Local Health System

Now, and over the next ten years, the challenges for health care are enormous. The population is aging, illness burden is high, resources are scarce, our ability to measure benefits of investments is poor, and, the economy is flat. The compelling directions emerging from clinical services planning, diabetes planning, mental health action plans, and community conversations call for a healthier population, better ways of working together, and appropriate distribution of best practice health services.

Our reach for health system improvement in the IHSP is bold, imperative, and feasible. The HNHB LHIN has a long legacy of collaboration for improvement. Hamilton's 20 year experience with community health centres and health service organizations and, now 13 Family Health Teams across the LHIN, prepare us well for LHIN-wide interprofessional care. Some community organizations are developing joint service plans to leverage resources for direct client care, reduce duplication and share best practice.

Collaborative planning for health system improvement is well underway in the LHIN. In the last three years, no fewer than 67 initiatives have been showcased at Ontario's *Celebrating Innovations in Health Care Expo*. Four initiatives were short-listed and one received top honours -- the *Provider-Patient Reminders in Ontario Multi-strategy Prevention Tools (P-PROMPT)* which boosts screening rates in Ontario for mammograms, pap testing, influenza vaccination and childhood primary vaccinations.

The launch of the HNHB LHIN Integrated Decision Support Business Intelligence tool (IDS BI) is a milestone; the tool will help plan, arrange, deliver, manage and account for people's care in the LHIN. Our readiness for just-in-time personal health information for decision-making is high; more than 2500 providers are enrolled in CinicalConnect, a provider portal. All HNHB LHIN hospitals will be connected to a diagnostic imaging repository in early 2010 to access patients' tests and reduce duplication.

Our vision is a health care system that helps keep people healthy, gets them ***good care*** *when they are sick, and will be there for our children and grandchildren.*

Finally, healthy people, healthy communities and health system improvement are a shared responsibility. We know that:

- health care accounts for 10% of health and well-being, with the balance related to lifestyle behaviours, genetic predisposition, social circumstances, and environmental exposure[8];
- solutions to problems lie in communities, with the people who get care and those who provide care; and
- increasingly, good data and information are providing evidence as to the benefits of investments in healthy living.

The LHIN will continue to engage broadly, listen intently, and make sound decisions. Health providers will continue to work together and ensure quality care and support. LHIN residents will participate in their own health care and tell us how the health system is working for them. The LHIN will work with community partners in housing, transportation, and social and public health services.

Our mission is to ensure availability of and access to linked services in order to ***improve*** *the health of the population and the continuity of health care.*

The Local Health Care System: A Snapshot

Our LHIN

The HNHB LHIN encompasses Brant, Burlington, Haldimand, Hamilton, Niagara and most of Norfolk county. The LHIN stretches from Fort Erie to Turkey Point and Paris to Lowville and covers approximately 7,000 square kilometers. Each community has a rich local identity and there are wide variations in population density. The LHIN includes both urban and rural land areas. While Haldimand and Norfolk have the greatest percentage of rural settlement, all communities in the LHIN include rural areas.

Economic and social forces are having an effect on the overall "health" and well-being of the population. As in the rest of Ontario, some people are concerned about unemployment, income security and, eligibility for the 21st century labour market. In October 2009, unemployment rates in Hamilton had increased 50% in two years, 27% in St. Catharines and had almost doubled in Brantford[9]. Social assistance rates in Hamilton and Niagara have increased 21.32%[10] and 18.63%[11] respectively over 17 months. With the loss of jobs and a manufacturing economy in transition, communities are at risk for a reduced tax base, outbound migration for economic opportunity elsewhere, and increased demand for social services. The potential impact on the capacity of communities to raise funds for capital investments and equipment improvements in health care, and health services, may be significant.

Our Population

The HNHB LHIN is home to more than 1.4 million people and is expected to grow to 1.5 million people by 2019[12]. Growth is variable across the LHIN and more than 70% of the population resides in the City of Hamilton and the Regional Municipality of Niagara. Population characteristics include higher rates of aging, diversity, and poverty as compared to Ontario as a whole.

The need for health care services increases with age, with hospital use rising sharply after age 65.

- More than 220,000 people 65+ years live in the HNHB LHIN. This age group will grow by 30% over the next ten years[13]. Niagara, Haldimand, and Norfolk have the oldest populations of all areas in our LHIN. HNHB LHIN has the largest population of seniors of all LHINs in the province.

Health seeking behaviours and practices are shaped by factors including age, gender, values, culture, belief systems, language, and sexual orientation.

- Hamilton has both the highest numbers and percent of visible minority populations in the HNHB LHIN.

The Aboriginal population has lower incomes, lower life expectancy and higher rates of illness, compared to the average Canadian[14].

- Six Nations of the Grand River Territory and Mississaugas of the New Credit are two First Nations in the HNHB LHIN. The total registered Aboriginal population in the LHIN is approximately 24,263 persons (1.7% of the total LHIN population) with about half the population living on Reserve[15]. Non-Status, Métis, and Inuit populations are not included in these population estimates.

The *Local Health System Integration Act, 2006 (LHSIA),* entitles people whose first language learned at home is French and who still understood French at the time of the 2006 Census to services in French.

- Almost 2.5% of the population in the HNHB LHIN is Francophone[16]. Both Hamilton and Niagara are designated communities for French language services, as more than 5,000 people in each area identify French as their mother tongue.

Low income and low education levels are associated with higher rates of illness, premature death, and use of health care services.

- About one in seven residents of the HNHB LHIN population live below the poverty line[17]. Rates of low income are higher among recent immigrants, Aboriginal peoples, visible minorities, and female lone parents.

Our Lifestyle

Obesity, physical inactivity, and smoking are the leading lifestyle factors related to premature death.

- Relative to the province, there are significantly higher rates of smoking, heavy drinking and obesity in the HNHB LHIN[18].

Our Health

Chronic conditions, such as asthma and heart disease, are often related to lifestyle behaviours such as smoking and physical inactivity.

- HNHB LHIN residents have higher rates of chronic conditions including arthritis, high blood pressure, and asthma compared to the province as a whole[19]. Diabetes rates are slightly, but not significantly, lower than provincial rates. There are variations in the prevalence of chronic conditions among population groups. For example, there are higher rates of many chronic conditions among Aboriginal populations.

Our Health System Characteristics

Ideally, most people get most of their health care, most of the time, in the community (not in hospitals), and most residents get most of their hospital-based services in the HNHB LHIN.

- Access to a family physician is variable across the LHIN. It is estimated that approximately 160,000 people (12% of HNHB LHIN residents) do not have a family physician[20]. People in Norfolk, Haldimand, and Niagara have considerable challenges finding a family physician.
- Treatment gaps for children and youth include eating disorders, paediatric rehabilitation, inpatient and ambulatory mental health services, and oncology[21].
- There are populations with low prevalence conditions that require high intensity services and whose needs are not adequately met as they age: persons with acquired brain injury, developmental disabilities, amyotrophic lateral sclerosis (ALS), spina bifida and minor head injuries[22].
- About half of all visits to the ED are for non-urgent and less urgent care.
- There is increased demand for CCAC services. The number of individuals served is anticipated to grow by 5% in 2010[23]; this reflects a similar growth pattern to that experienced over the past two years. Key pressures in the growth pattern are seen in the 36% increase in long-term care supportive clients and the 18% increase in maintenance clients[24].
- The number of LHIN residents receiving hospital-based care outside the LHIN is low[25]. Reasons for leaving the LHIN for care include the need for a highly specialized service, close proximity to another LHIN, residents using services closer to work or family, or, as a result of provincial wait list management for timely care. Obstetrics, general surgery, psychiatry and cardiac care account for 50% of inpatient hospital care received by residents outside the LHIN.
- A significant number of patients in complex continuing care are waiting for alternative care in another setting[26].
- Transportation to get to medical care is not equitably available to LHIN residents who need it. There is considerable variability in available public transportation and variability among private and non-profit alternatives by geography, hours, eligibility, user fees, and accessibility[27].

Education, Training and Research

The Faculty of Health Sciences, McMaster University makes a significant contribution to safe, effective and sustainable health services.

The Faculty of Health Sciences, DeGroote School of Medicine at McMaster University in Hamilton (the Faculty) is one of six medical schools in Ontario. There are two academic health science centres in Hamilton – Hamilton Health Sciences and St. Joseph's Healthcare Hamilton (also referred to as teaching hospitals), characterized by their mission of clinical service, education and training, and research. In 2009, partnerships with the Niagara Health System and Brock University supported the establishment of the Michael G. DeGroote School of Medicine Niagara Regional Campus. The Regional Campus will move into the new Niagara Health and Bioscience Research complex currently under construction at Brock University.

The Faculty provides active leadership for advancing the education and training of future health care professionals in diverse health settings in communities across the LHIN, alongside Mohawk College and Brock University. In this leadership role, The Faculty is advancing interprofessional care, optimal practice scope and best practices. Other hospitals, community agencies, physicians' offices and clinics are official teaching sites for Health Science students.

Our Performance

	Wait Times Target 2009-10	Current Year July-Sept 2009	Trend
Cancer Surgery	50 days	61 days	▲
Bypass Surgery	182	77	▲
Cataract Surgery	103	97	▼
Total Hip Replacement	182	168	▲
Total Knee Replacement	182	220	▲
Magnetic Resonance Imaging (MRI)	87	99	▲
Computerized Tomography (CT)	33	50	▲

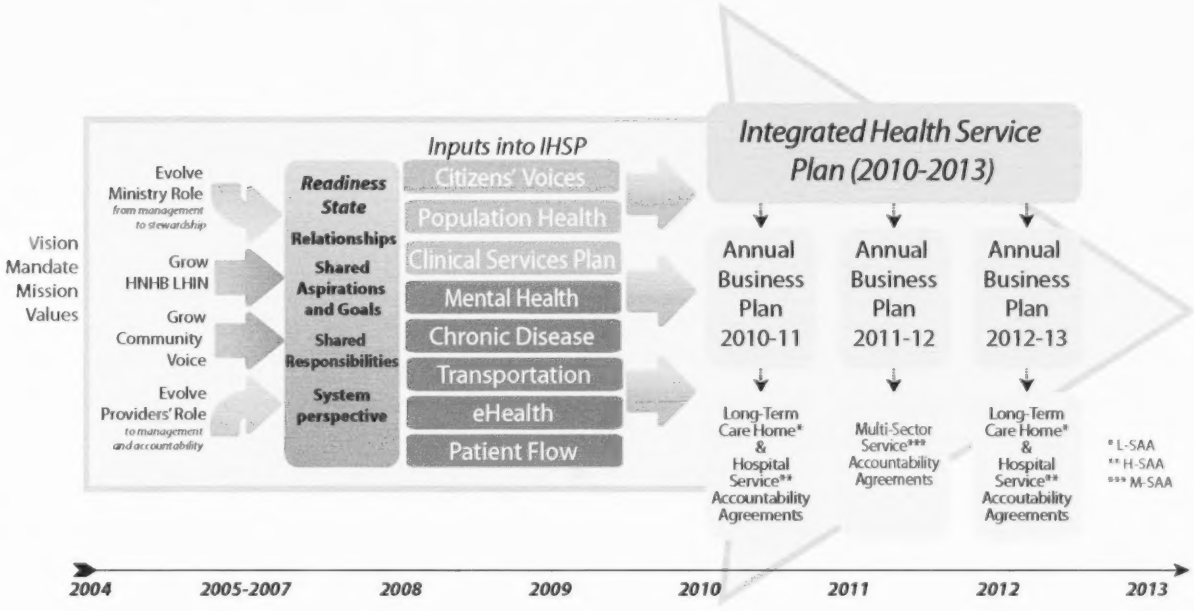
△ - increasing ▽ - decreasing ▷ - little or no change

- trend is good - trend requires monitoring - trend is worsening

Reducing wait times for people requiring health care services is a government priority for Ontario. Among its performance responsibilities, the HNHB LHIN monitors wait times for priority clinical services and works with providers to advance best practice, scope of practice, and outcomes. Goals include improved patient experience, quality care, and efficient services.

Framework for Planning

The Integrated Health Service Plan is the outcome of a step-wise approach to strategic directions for priority improvements over the next three years. Foundational tenets to building the IHSP are community engagement and evidence-based decision-making.

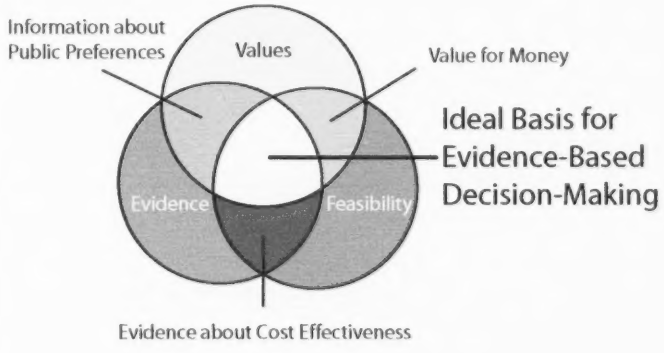


Engaging Communities

Engaging people in conversations about what health care should look like to improve access, outcomes and people's experience is an ongoing process. Periodically, milestone events focus on one or more issues. *Let's Talk*, *First Nations Search Conference*, *Raising the Bar in Chronic Disease Prevention and Management*, *Every Door is the Right Door*, and *Discover Learn Share* are examples of one-time or continuous engagements that inform planning and decision-making.

Our decision-making is guided by understanding and linking the values and preferences of communities, the evidence as to what will make a positive difference, and the feasibility of preferred solutions.

Evidence-based decision-making is based on information from the intersection of values, feasibility, and evidence.



Discover Learn Share

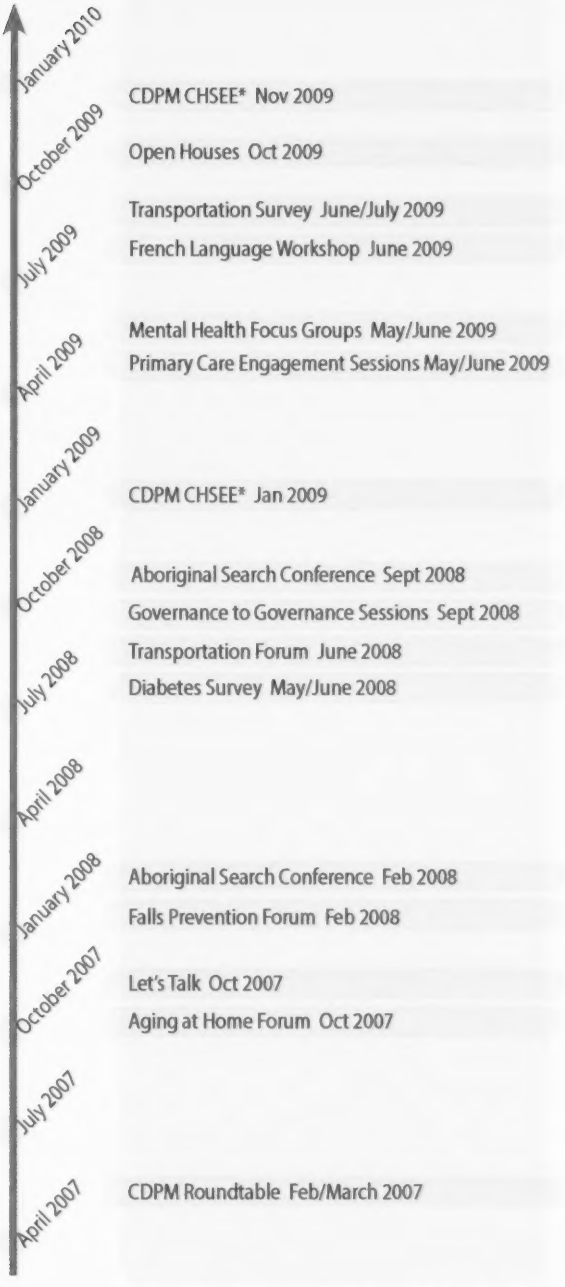
Discover Learn Share was a series of 12 open houses held in October 2009. This was an opportunity for residents, stakeholders and providers to share their perspectives about current and future health care. The LHIN listened and learned.

As we look ahead, health plans will answer:

- What is changing and why?
- What are the responsibilities of the ministry, the LHIN, providers, communities and individuals?
- How will change assure access to timely, safe, quality, services no matter where people live?

Open House, Hagersville United Church, Hagersville, October 15, 2009

Engagement Strategy Timeline:



* CHSEE - Continuing Health Sciences Education Event

Open House, Eva Rothwell Resource Centre, Hamilton, October 20, 2009

An Overview of Our Priorities

The priorities for the HNHB LHIN are colour coded for easier reading. They are summarized as follows:

Patient Flow -
Helping People get the Right Care, at the Right Time, in the Right Place

- Alternate Care Settings
- Emergency Department Capacity
- Clinical Program Integration
- Community Based Health Service Capacity
- Aboriginal Health
- Francophone Health

Chronic Disease Prevention and Management -
Reduce Prevelance of Chronic Disease and Improve Care Delivery

Mental Health and Addictions -
Linking Services for Prevention, Management and Recovery

Enablers for Transformation

- eHealth
- Inter Professional Care
- Transportation
- Partners for Change

Alternate Care Settings

...A Patient Flow Priority

Getting people to the right care following a hospital stay

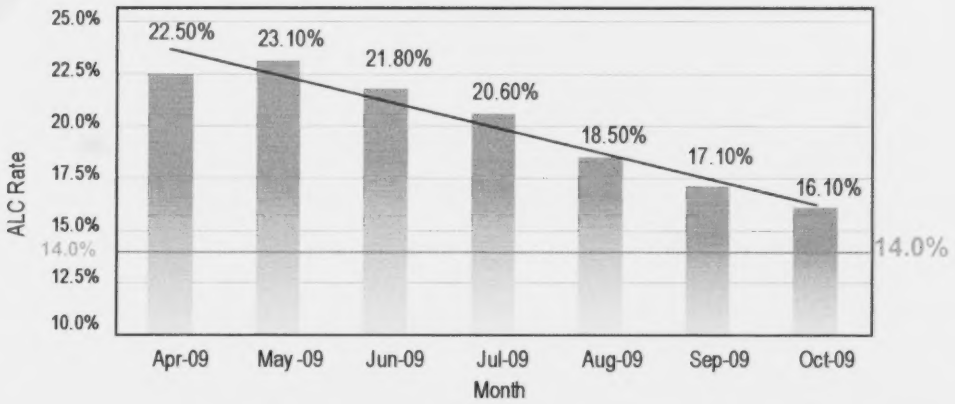
Improve access to hospital care by reducing the amount of time (the ALC rate) that patients wait in hospital for alternate care when their hospital care is complete.

Historically, a long-term care home was often considered the most appropriate destination for frail, elderly persons after care in the hospital was complete. "Home First" is a philosophy that respects people's choice, independence and safety. The "Home First" initiative is designed to identify and bundle linked services for the right care, at the right time, in the right place. An intentional focus on matching patients' needs with available resources reduces wait times in hospital for discharge and frees up hospital beds for admitted patients.

Core Components of the HNHB LHIN Patient Flow Strategy

Population Health Profile	Reduce Emergency Department Demand	Improve Emergency Department Capacity/ Performance	Reduce Alternate Level of Care Rate	Supports in the Community
Access Demographics Capacity	Improve access to primary care and community support	Improve patient flow and operational efficiency	The right care at the right time in the right place	A community care service model that supports a quality of life and sustains clients in their homes

HNHB LHIN Alternate Level of Care (ALC) Rate



Data Source: HNHB CCAC: Hospital ALC Summary Report, October 2009

Goal: Reduce Alternate Level of Care Rates

Objectives

LHIN-wide Strategies

The Right Care at the Right Time in the Right Place

Home First
A patient and their health care team are planning for discharge from hospital to home with the services and supports that a patient needs

Nurse-Led Outreach Teams
Nurse Practitioner visits to LTC Home residents provide assessment and treatment to LTC residents, and education to staff

Timely Access to Complex Continuing Care and Rehabilitation
Utilization review

Specialized LTC Services
Identifying a service delivery model for LHIN residents requiring long-term ventilation and peritoneal dialysis

Moving Patients to an Appropriate Interim Health Care Setting

Assess Restore Units
Unit where (ALC) patients from acute or post-acute care receive specialized restorative care focused on returning them to home or be assessed for their long-term care needs

Slow Stream Rehabilitation
Low intensity, longer duration rehabilitation to improve a patient's functional abilities

Interim Rehabilitation Beds
15 additional interim rehabilitation beds in Niagara to address shortage of facilities

Long-Term Care Overbeds
15-16 LTC beds over and above licensed capacity for a short period of time to offset LTC Home placement wait lists

Expansion of Community Support
Implementation of the Aging at Home initiatives to improve quality of life and access to community services, avoiding hospital admissions

Enablers

Service Accountability Agreements
Health Service Provider service accountability agreements include a provision to meet the LHIN ALC performance target of 14% by March 31, 2010

Leglislative
Increase in service delivery maximums (greater than 60 hours) for CCAC-managed clients

ALC Information System (eHealth)
Tool developed to facilitate hospital reporting of ALC data from hospitals to the Wait Time Information System

FLO Collaborative
Applying LEAN methodologies to facilitate process improvement to enhance the timeliness and effectiveness of patient transition from acute medicine units to subsequent care destinations

ALC Communications
A flyer explaining the Home First approach is available to all hospital patients and their families

Performance Goals

- The LHIN target of 14% acute ALC will be met by March 31, 2010
- Decreased ALC rate for hospitals
- Reduce the number of patients identified as ALC
- Shorten lengths of stay for ALC patients
- Age and acuity of clients admitted to LTC homes increases
- Reduce elective surgery cancellations due to no beds available

Emergency Department Capacity ...A Patient Flow Priority

Reducing Presentations to the Emergency Department

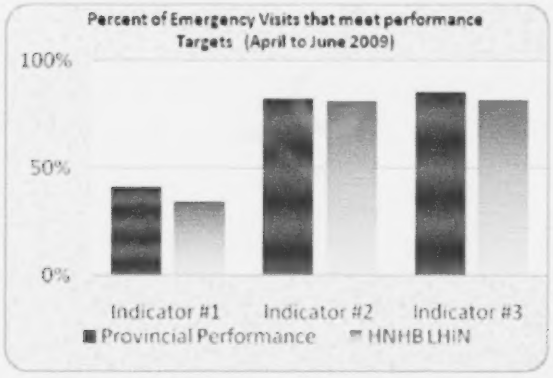
Improve access to emergency care by reducing the number of non-urgent or less urgent presentations to the emergency department, and reducing the amount of time that people spend waiting.

Some patients who visit the emergency room for assessment and treatment potentially have alternate health care settings for care such as family doctors, family health teams, urgent care centres, walk-in clinics, or long-term care homes.

Reducing Wait Times in the Emergency Department

Improve Emergency Department capacity and efficiency.

Emergency Department (ED) Wait Times are measured by the total number of hours a patient remains in the ED.



EDRS – HNHB LHIN ED Pay for Results Report June 2009

Pay for Results (P4R)

Seven LHIN hospital sites have implemented initiatives under the Ministry of Health and Long-Term Care Pay for Results Strategy. This strategy is aimed at improving ED capacity by focusing on process improvements that result in increased efficiency.

To better identify process changes that will improve the client's experience in the ED, all the LHIN Pay for Results hospital sites are participating in the provincial ED Process Improvement Program (PIP). This program expands beyond the ED and assists hospitals to look across their organization with the goal of improving the quality and timeliness of client care.

Indicators are used to measure the progress made for improving the patient care experience in the emergency department.

Indicator #1: Admitted patients will spend eight hours or less in the ED

Indicator #2: Non-Admitted High Acuity patients will spend no more than eight hours or six hours in the ED, depending on their level of acuity

Indicator #3: Non-Admitted Low Acuity patients will spend no more than four hours in the ED

Goal: Reduce Wait Times in the Emergency Department

Objectives	Reducing Avoidable Emergency Department Visits	Improving Emergency Department Capacity - Pay for Results Initiatives
Strategies	**Mobile Primary Care Team for Francophone Seniors** Screening, specimen collection, medication management, grief counseling, physiotherapy in seven facilities and to seniors in their home	**Express Unit** Alternate inpatient unit (12 hours per day) for people ready for discharge or in ED waiting to be admitted
	Palliative Care Outreach Team Outreach expansion in a rural area	**Rapid Assessment Zone** Fast track assessment process for low acuity patients
	Diabetic Foot Care and Education Expanded foot care in two communities	**Patient Flow Coordinator** Facilitates timely access to inpatient beds from the ED
	Community Incontinence Self-Management LHIN-wide program to advance self- management practices and reduce falls	**Housekeeping and Porter Services** Dedicated support services to the ED
	Specialized Geriatric Services Expansion Eight community assessment clinics a month in adult day programs, family health teams and community health centre	**Medical Directives** Standardized protocols for assessing presenting symptoms for selected conditions to expedite care
	Falls Prevention Strategy Education and uptake of best practice guidelines, and expansion of programs	**Streamlined Triage** Dedicated triage nurse for adults and children at McMaster Children's Hospital
	Nurse Practitioner in LTC Home	**Physiotherapy Coverage** Available Physiotherapy assessment on weekends and statutory days in the ED
	CCAC Case Managers in ED Hospital admission avoidance	
Enablers	**Integrated Decision Support Tool** A LHIN-wide business intelligence system that supports system wide-planning and performance reporting, and evidence-based decision making for administrative, planning and operational requirements	
	Health Care Connectors Connect people without a family doctor to primary care	
	New Urgent Care Centres and Ambulance Transfer Low acuity patients seen at the Urgent Care Centres in Port Colborne, Fort Erie and Hamilton rather than an emergency department	
	Process Improvement: LEAN[28] Province-wide quality improvement initiative that assists hospitals to improve organizational effectiveness and efficiencies for improved patient satisfaction, patient flow and outcomes. Currently in seven hospital sites. Includes certification in LEAN for all hospital, Emergency Medical Services (EMS) and CCAC quality improvement leadership	

Performance Goals

- Reduce avoidable emergency department admissions and inpatient hospitalizations
- Admitted patients treated within the length of stay target of up to eight hours
- Non-admitted low acuity patients treated within the length of stay target of up to four hours
- Non-admitted high acuity patients treated within their respective targets of up to eight hours for CTAS I-II and up to six hours for CTAS III (CTAS - Canadian Triage and Acuity Scale, refer to page 37)

Clinical Program Integration

...A Patient Flow Priority

About Clinical Program Integration

Now, and over the next ten years, the challenges for health care are enormous. Our population is aging, illness burden is high, resources are finite, our ability to measure benefits of investments is poor, and the economy is in transition. The HNHB LHIN Clinical Services Plan (November 2009) is an action call for a healthier population, improved ways of working together for better health outcomes and best practice organization, and distribution of programs. One of three strategies to achieve these goals is clinical program integration.

Future Demand

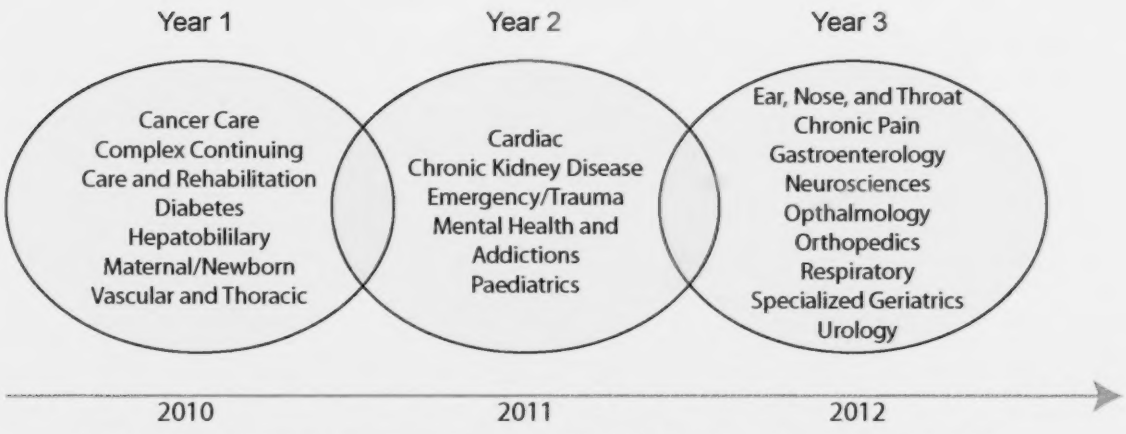
The Clinical Services Plan estimated that future demand for hospital services would grow by approximately 30% if the status quo prevails.

The LHIN is committed to reducing demand for hospital services through strategies that improve overall health of the population, promote self care, and align community-based health services with independence, wellness and recovery goals.

Clinical Program Integration

"Health care programs will be reorganized and distributed to improve access, quality, and efficiency. This will eliminate, for instance, unnecessary duplication of low volume, high complexity services and ensure appropriate use of health human resources, buildings and equipment. Integrated programs will be led by one or more organizations, and guided by clear roles and shared accountabilities, best practice standards and guidelines, and common protocols for client transitions along the care path."

(HNHB LHIN Clinical Services Plan, November 2009)



Phased implementation of integrated clinical programs reflects readiness, leadership and flexibility

Goal: Equitable Access to Safe, Accessible and Sustainable Services

Objectives	Implementation Strategies	Early Actions - Year 1
Implement Clinical Service Plan direction: **Clinical program integration**	Identify program size, scope, and distribution	
	Establish clear roles, responsibilities and accountabilities	Adopt LHIN-wide charter for clinical program integration endorsed by stakeholder leadership
	Implement best practice clinical standards and guidelines	
	Adopt common admission discharge and referral guidelines	Establish LHIN-wide hospital credentialing for physicians, dentists, midwives and nurses
	Eliminate duplication of low volume high complexity services	Develop a functional program for LHIN-wide integrated laboratory medicitne
	Implement evaluation and performance monitoring metrics	Implement Year 1 LHIN-wide integrated programs
	Implement the Hamilton Health Sciences Access to Best Care Plan	
	Implement the Niagara Health System Hospital Improvement Plan	
Better integration of primary and specialized care (refer to page 28)		
Build eHealth infrastructure to support communication and shared information		

Performance Goals

- Improve client/patient experience
- Common assessment, referral, placement/admission and discharge criteria
- Reduce wait times
- Reduce duplication
- LHIN-wide performance indicators

Community-Based Health Service Capacity

When we look at the characteristics of people in hospital ready to return to the community, the ***readiness*** *of our community programs is key.*

About Community Capacity

Most people's health and wellness is supported by access to housing, income, education, safe communities, healthy living and clean air. Community-based health and social services also contribute to health, wellness and independent living. They:

- support independent living for people of all ages; services include supportive housing, food, transportation, friendly visiting, and congregate programs;
- promote early detection and intervention; services include screening, immunization, case finding, diabetes education, and foot care;
- prevent hospitalization; services include falls prevention, palliative care, alternative medicine, and ambulatory services, and
- provide continuity of care and recovery after hospital care.

Community services linked with primary care together provide a basket of health and wellness services close to home.

Navigating Community Services

From the individual's perspective, it can be hard to find services, know which services are right for them, and, difficult to travel to services. Services are not equitably distributed across the HNHB LHIN, and there are no standardized tools for client assessment, care planning, and outcomes evaluation to ensure the availability of right care, at the right time, in the right place.

At the same time, programs and services are challenged by population needs (for example growing demands for service and increasing number of clients with complex needs). Resource limitations include a shortage of health professionals and volunteers, wage disparities with other sectors, funding constraints, and a competitive fundraising environment.

Characteristics of Patients Ready for Return to the community

Some people in hospital experience difficulty returning to the community. They often share the following characteristics[29]:

- High to very high difficulties with their instrumental activities of daily living for example, housekeeping, meal preparation, taking medication, and doing laundry.
- More than 50% have moderate to very high impairment in the activities of daily living for example, eating, bathing, dressing, personal hygiene, getting around, and going to the bathroom.
- Take nine or more medications.
- More than a third have moderate to very high cognitive impairment.
- More than a third are incontinent frequently or all the time.
- Suffer from multiple chronic conditions for example hypertension, arthritis and congestive heart failure.
- Are predominantly senior women.

What do they need in the community?

- Coordinated care provided over extended periods of time
- Various levels of health care and human services
- Social and family supports and traditional health care services.

Community-Based Health Service Capacity

"Most people will continue to get most of their health care, most of the time, in the community. Community services for health, wellness and recovery will be aligned with population health goals, such as reduced diabetes and chronic lung disease, and improved mental health. Decision support tools and improved client matching processes will link people with the appropriate level of care in the right setting. Robust and linked community services will improve patient/client flow, and reduce inappropriate demand for hospital care."
(HNHB Clinical Services Plan, November 2009)

Goal: Linked Services for Population Health and Continuity of Care and Support

Objectives	Implementation Strategies	Early Actions - Year 1
	Provide people with information and support to participate in their care plan	Implement community service access points
	Align community services with population health and system improvement goals	Identify range, scope and distribution of required assisted living services in the LHIN
	Implement process improvements for improved organizational capacity	Continue to implement and evaluate the Aging at Home strategy
Optimize community-based health resources	Increase adoption of evidence-based programs and practices	Implement falls prevention programs
Improve access to care and support	Adopt client-directed care and choice	Implement *Residents First: Advancing Quality in Long-Term Care Homes*, a quality improvement initiative in partnership with the Ontario Health Quality Council
	Implement demand modeling tools for proactive capacity building	
	Reduce emergency department visits and avoidable hospitalizations	Implement standard tools across programs and services for assessment, care planning, referral, and outcomes evaluation
Connect more people without a family doctor to primary care		
Build eHealth infrastructure to support communication and shared information		

Performance Goals

- LHIN-wide uptake of common assessment and referral tools, and performance metrics
- A business plan for assisted living consistent with the ministry's pending policy
- People tell their health story once
- Reduce presentations to emergency departments and hospitalizations due to falls
- Reduce wait times for access to community services (e.g. adult day programs) and care and support requirements on leaving hospital
- Improve residents' health care experience

Aboriginal Health

...A Patient Flow Priority

About Aboriginal Health

Aboriginal health and wellness is guided by the relationships among three concepts: the life cycle, wholistic health, and the healing continuum. Aboriginal people in the LHIN identified opportunities to enhance health and well-being for people in their communities at a three day conference (February/March 2008). These aspirations are shaping the partnerships for change over the next three years.

Soaring Vision Aboriginal Health Search Conference, February/March, 2008

Goal: Healthy Families, Healthy Children

Objectives	Implementation Strategies	Early Actions - Year 1
	Implement Conference health and well being aspirations	Link health service providers to best practices for welcoming and responsive organizations
Reduce health disparities	Adopt culturally appropriate care for healing, recovery and good health	Implement supportive housing for Aboriginal persons with addictions
Improve family and child health		Implement the first of six dialysis stations at White Pines Wellness Centre
Reduce chronic disease	Establish welcoming environments in health service provider organizations	Establish diabetes education centres
	Reduce avoidable ED visits and hospitalizations	Use data and decision support tools for improved patient flow planning and decision-making
Connect more Aboriginal people without a family doctor to primary care		
Build eHealth infrastructure to support communication and shared information		

Performance Goals

- Improve health outcomes
- Make available programs and services deemed priorities by Aboriginal communities
- Improve client/patient satisfaction
- Increase culturally competent practice
- Include aboriginal stakeholders and entities in planning and decision-making

Francophone Health

...A Patient Flow Priority

About Francophone Health

The *French Language Services Act*, Ontario, 1986, recognizes the contribution of the French speaking population to the historical, cultural, and linguistic heritage of Ontario. The Act guarantees the right of French speaking Ontarians to communicate with the government and receive services in French.

Did you know?

- More people want services in French than are asking for them in the HNHB LHIN.
- People are not comfortable asking for services in French.
- People do not know what services are available in French and where.
- French speaking health professionals are in short supply.
- Programs and services are not tailored to the needs of Francophone communities.
- There is variable commitment among stakeholders to meeting the needs of French speaking people.

Goal: Healthy Families, Healthy Children

Objectives	Implementation Strategies	Early Actions - Year 1
Every door leads to services in French	Establish welcoming environments in health service provider organizations	Link health service providers to best practices for welcoming and responsive organizations
		Assess French language capacity in community-based health service organizations
	Improve French language health care service capacity	Establish the French language planning entity
	Reduce avoidable ED visits and hospitalizations	Use data and decision support tools for improved patient flow planning and decision-making
Connect more Francophones without a family doctor to primary care		
Build eHealth infrastructure to support communication and shared information		

Performance Goals

- Programs and services deemed priorities by Francophone communities are available in French
- Improve access to French language services
- Improve client/patient satisfaction with French language services
- Increase culturally competent practices
- Include French speaking stakeholders and entities in planning and decision-making

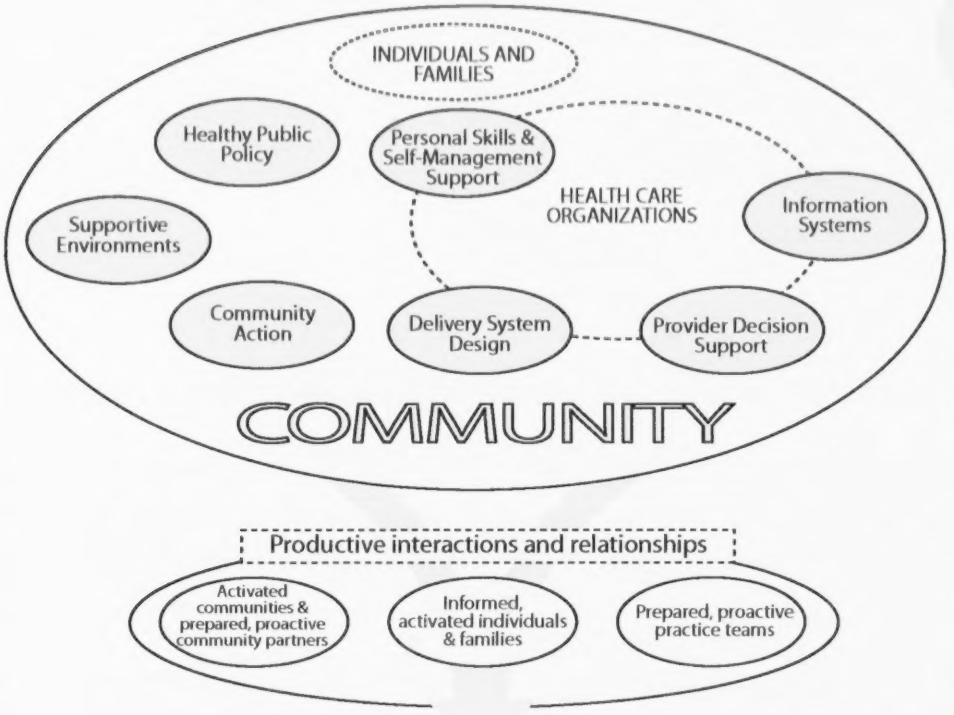
Chronic Disease Prevention & Management

About Chronic Disease

Chronic conditions (also known as chronic diseases) are health conditions that require care over time. These conditions include heart disease, diabetes, and asthma. Chronic conditions are the leading cause of illness, disability and poor quality of life. While not all chronic conditions have the same impact on a person's quality of life, they can generate a significant burden to individuals, their families, the work force, the health system and communities. The good news is that chronic conditions can be managed and even prevented. People living with chronic conditions can lead relatively healthy lives.

What does this mean for our LHIN?

- More than a million people in the HNHB LHIN report one or more chronic condition(s).
- The chances of developing a chronic condition increase as people get older
- People with chronic conditions earn less, miss more work, and are more likely to retire early
- People with asthma, arthritis, diabetes, or heart disease often report having "fair" or "poor" health
- People with chronic conditions who require assistance with activities of daily living may depend on community support services, formal home care or informal caregivers (family or friends) to meet their needs
- Informal caregivers often feel stressed as a result of their responsibilities and report reduced productivity in the workplace
- Each year more than 200 people in the HNHB LHIN have a foot or lower limb amputated due to complications with diabetes



The Ontario Model

A provincial model for Chronic Disease Prevention and Management (CDPM) (2006) guides changes in health care practices and health systems that are improving CDPM in Ontario. The model outlines the importance of the many factors that influence chronic conditions and the amount of collaboration that needs to occur across all sectors.

The HNHB LHIN will implement this model through the Triple Aim approach (refer to page 38).

Goal: Reduce the Prevalence of Chronic Disease and Improve Care Delivery

Objectives	Implementation Strategies	Early Actions - Year 1
	Implement initiatives to achieve the goals of the Ontario Diabetes Strategy	Expand diabetes education centres
		Expand foot care services for persons with diabetes at high risk
Reduce the prevalence of chronic disease	Optimize person-directed care and choice (self management)	Implement peritoneal dialysis units in three long- term care homes
A local health care system that meets the needs of people with chronic disease	Increase adoption of evidence-based practices in chronic disease prevention and management	Continue annual sponsorship of the continuing health sciences education event
Alignment of the LHIN municipalities, and other ministries to improve the health of the population	Reduce emergency department visits and avoidable hospitalizations	Implement standardized practice guidelines
		Establish change coalition for diabetes and COPD prevention and management
	Identify populations (by geography, age cohort, gender) at risk for diabetes and Chronic Obstructive Pulmonary Disease (COPD)	Disseminate diabetes and COPD best practices for prevention and management
Connect more people living with diabetes and COPD and without a family doctor to primary care		
Build eHealth infrastructure to support communication and shared information		

Performance Goals

- Improve client/patient experience
- Identify risk factors associated with a diabetes and COPD in defined populations
- Reduce avoidable ED visits and hospitalizations for populations with diabetes and COPD
- Prevent or reduce the incidence of diabetes and COPD in new populations
- By 2013, achieve a 10% reduction in lower limb amputations in the HNHB LHIN for individuals with diabetes

Mental Health and Addictions

Adapted from **Every Door is the Right Door** *a 10-Year Mental Health and Addictions Strategy, July 2009 - a report from the Ministry of Health and Long-Term Care*

About Mental Health and Addictions

The people touched by mental health and addictions are our family members, friends, and colleagues. The impacts are significant; mental illnesses and addictions can cause people to lose their jobs, their friends, or their homes. Because mental illnesses and addictions are not well understood, they can also affect communities, creating stigma and fear. Untreated mental illness is costly for health care and related services, as well as for businesses and the economy as a result of lost opportunity and productivity.

What does this mean for our LHIN?[iii]

- One in five Canadians - *280,000 people in our LHIN* - are affected by mental illness at some time in their lives.
- 70% of people with mental health issues - *196,000 people in our LHIN* - have them before they are age 18.
- Less than half of all children and youth in need of treatment get treatment. *98,000 children and youth in our LHIN do not get the treatment they need.*
- Between 10% and 20% of people - *140,000-280,000 in our LHIN* - will have a substance use disorder in their lifetime.
- 3% depend on alcohol and illicit drugs in a given year. *This year, in our LHIN, 42,000 people will depend on alcohol and illicit drugs.*
- 5% - *70,000 people in our LHIN* - have the potential to become, or are already, problem gamblers.

Our Mission

- Every door is the right door for Ontarians with mental illnesses and addictions.
- All doors in the mental health and addictions system and the broader health system lead to integrated, accessible, person-directed services and supports. The broader health system includes children and youth services, education, social services, housing, seniors' services, settlement services, and justice.
- Services focus on the hopes and needs of people with mental illness and addictions, and engage them in their own health and care.

Proposed Strategies

- *Act Early* - Identify mental health and addictions problems early and intervene appropriately.
- *Meet People on their Terms* - Develop a range of evidence-based, person-directed services.
- *Transform the System* - Provide access to a seamless system of comprehensive, effective, efficient, proactive and population specific services and supports.
- *Strengthen the Mental Health and Addictions Workforce* - Ensure we have the right people with the right skills in the right places.
- *Stop Stigma* - Bring mental health and addictions out from behind closed doors.
- *Create Healthy Communities* - Fostering supportive communities is a shared responsibility that requires the commitment of all segments of society and cooperation of all government ministries.
- *Build Community Resilience* - Protect people from mental illness and addictions.

Goal: Integrated and Linked Services for Prevention, Management and Recovery[11]

Objectives	Implementation Strategies	Early Actions - Year 1
Implement the Mental Health and Addictions 10-year Strategic Plan (MOHLTC)	Implement initiatives to achieve the goals of the 10-year strategy	Expand the participation of people living with mental illness and addictions in program governance, design, and evaluation
	Optimize person-directed care and choice	Expand screening tools in primary care practice
	Improve early detection and prevention	Expand supportive housing for people living with addictions
Reduce the prevelance of mental illness and addiction	Reduce emergency department visits and avoidable hospitalizations	Expand specialized geriatric services in priority LHIN communities
	Increase the adoption of evidence-based practices in mental health and addictions prevention, management and recovery	Establish change coalition for mental health and addictions improvement
		Continue to sponsor best practice forums in partnership with the Centre for Addictions and Mental Health
Connect people living with mental illness and addictions without a family doctor to primary care		
Build eHealth infrastructure to support communication and shared information		

Performance Goals

- Improve client/patient experience
- Increase inclusion rates of people living with mental illness and addictions in program governance, design and evaluation
- Increase screening rates in primary care practice
- Reduce avoidable ED visits and hospitalizations
- Increase local access to specialized geriatric services

eHealth

...An 'Enabler for Transformation' Priority

> *"Our government is introducing LHINs in order to* ***integrate and improve*** *the way health care is planned, coordinated and ultimately delivered to Ontarians. A comprehensive eHealth strategy is a big part of that plan, and Ontarians will see the difference it makes in the quality of care they are receiving*[30]*"*

A Strategic Plan

The HNHB LHIN released its eHealth Strategic Plan in October 2006. This Plan outlined how the LHIN would deliver a comprehensive, patient-focused and secure electronic system that would improve the way patients receive care. As importantly, it proposed principles to guide business planning and grow eHealth.

- Build on existing and scalable solutions
- Seize opportunities and align with current or planned initiatives and resources
- Choose solutions that promote ease of integrations and operation with other systems
- Equip stakeholders with a minimum level of computerization to enable their participation
- All providers who stand to benefit and improve patient care should share implementation and sustainability costs

Growing eHealth - Making Progress

CCAC common case management tool (CHRIS)
Client-centred web-based system that supports client intake and referral, assessment and tracking, service monitoring and client data management. *HNHB CCAC went live, March 2008.*

RL Solutions Risk Management
Provides hospitals and the CCAC with the ability to manage incidents, i.e. any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of an individual, through the entire life cycle of that event – from occurrence to resolution. *Implemented at all LHIN hospitals and the HNHB CCAC.*

Interim Right Level of Care Information System (RLCIS)
Local information system that facilitates hospital acquisition and reporting of data elements necessary to meet provincial and LHIN ER/ALC reporting requirements in an efficient manner. *Launched November 2009.*

Regional Diagnostic Imaging repository – DI-r
Provide hospital-based clinicians and other health care providers access to patient images and diagnostic imaging reports acquired from any participating hospital in the HNHB and WW LHIN. *100% participation June 2010.*

Patient Centric Transformation Initiative (PCTI)
Build tools to profile patient's journey in the health system across multiple sectors. Findings will inform quality improvements for transitions, reducing unnecessary and/or duplicate use of services and resources, and avoidable ED visits. *Project is being rescoped to integrate other data elements e.g. physician billing information. Business case is being prepared for the ministry.*

Integrated Decision Support Strategy (IDS)
A LHIN-wide business intelligence system that supports system-wide planning and performance reporting. Data (from all hospitals and the CCAC) and reporting features facilitate timely, evidence-based decision-making for administrative, planning and operational requirements. *Launched November 2009. Hosted by Hamilton Health Sciences.*

Integrated cancer ehealth strategy
Integrated ehealth strategy for the Juravinski (Hamilton) and Walker Family (St. Catharines) Cancer Centres. Includes connectivity for community hospital cancer clinics. *Implementation underway. Walker Family Cancer Centre expected to open 2012-2013.*

Provider Patient Reminders in Ontario Multi-Strategy Prevention Tools (P-Prompt)
Boosts screening rates in Ontario for mammograms, pap testing, influenza vaccination and childhood primary vaccinations for physicians' patients. LHIN Project Management Office is funding some rural physicians to sign-up. *Hamilton Family Health Team (FHT) and 12 rural physicians' offices are participating.*

Drug profile viewer

Enables access to prescription drug claim histories of Ontario Drug Benefit (ODB) recipients by health care providers in some hospital emergency departments. *St. Joseph's Healthcare Hamilton and Niagara Health System are part of Wave 1 implementation.*

Common clinical viewer – ClinicalConnect

The portal enables timely provider access to patient and client information, across hospitals, other health care organizations, physicians and providers. ClinicalConnect closes information gaps, and reduces phone calls, repeat diagnostic tests, and medical errors, and improves patient outcomes and safety. *Enhancements underway: a single, sign-on web-based interface has been created to download to physician office medical record systems, CCAC data, and St. Joseph's Healthcare Hamilton. Mobile Access via Blackberry, iPhone and Windows Mobile Is under development. Next data sets for inclusion include information from other HNHB LHIN hospitals and oncology data from the Juravinski Cancer Centre.*

Goal: Linked Information for Effective Care and Health System Decision-Making

Objectives	Implementation Strategies
	Provide people with information and support to enable them to stay healthy, participate in their care delivery and improve their health care experience
Improve people's ability to make informed decisions	Help practitioners focus more on patient care and less on administration by enabling appropriate, secure and real-time access to patient information
	Improve access and streamline the coordination of care across care settings through enhanced cross provider sharing of information
Improve patient care delivery	Improve quality and safety of patient care through information and tools that help practitioners reduce errors and make better decisions
	Support effective health care and provide management and accountability through performance and outcomes based management information
Improve health system management	Enable health services planning decisions through access to timely and accurate information on population health needs and health care provider capacity
	Reduce costs and improve utilization of limited resources with information that enables providers to operate more efficiently and effectively.
Build eHealth infrastructure to support communication and shared information	

Performance Goals

- Reduce repeat diagnostic tests
- Reduce medical errors
- Improve outcomes
- Bridge gap between information silos
- Improve patient safety
- Increase patient, physician and staff time savings with less manual processing
- Improve work flows
- Reduce phone calls to get patent results
- Improve patient care

Interprofessional Care

...An 'Enabler for Transformation' Priority

> *A health care system that supports* ***effective teamwork*** *can improve the quality of patient care, enhance patient safety, and reduce workload issues that cause burnout among health care professionals.*[31]

About Interprofessional Care

Interprofessional care is the provision of comprehensive health services to patients by multiple health care professionals who work collaboratively to deliver the best quality of care in every health care setting. It encompasses partnership, collaboration and a multi-disciplinary approach to enhancing care outcomes and is the cornerstone of the HealthForceOntario strategy.

The current system is unsustainable

Current health status indicators and hospital utilization data in Ontario indicate higher than average rates of chronic health conditions and disease. These are associated with lifestyle behaviours and increased hospitalization in the HNHB LHIN. With no changes in health status and current utilization practices, the anticipated growth in the HNHB LHIN hospital system alone is unsustainable.

What does this mean for our LHIN?

Approximately 12% of the HNHB LHIN population (160,000 people) is without a family physician (derived from the number of underserviced area vacancies multiplied by 1,380 - the benchmark physician: population ratio for family physicians). Inadequate access to primary care, preventative care and self-management awareness contributes to avoidable emergency department visits and hospitalizations. Among primary health and primary health care entities, there is a lack of communication, coordination and use of best practices for optimal outcomes.

Gaps and Barriers

The HNHB LHIN Clinical Services Plan (2009) identified:

- little training and/or exposure to inter-professional care;
- a lack of awareness among health professionals as to respective training and practice scopes, and professional and organizational mandates;
- variable IT capacity and competency with IT; and
- multiple interpretations of client-centred or client-directed care.

The gaps are particularly acute in the areas of chronic disease management, mental health care and care for frail elderly, wherein no practitioner/entity can alone manage optimal care.

Readiness

Readiness is high to expand and adopt interprofessional care. This readiness builds on the Ontario experience with the "team" approach in palliative care, critical care and stroke care, the legacy of health service organizations in Hamilton and the growing numbers of family health teams and community health centres in the HNHB LHIN.

Interprofessional Care

"Health providers will work collaboratively to provide comprehensive, quality health services within and across settings, with a strong focus on health promotion, disease prevention, screening and self-management. Interprofessional care "teams" may include social workers, nurse practitioners, family physicians, pharmacists, traditional healers, optometrists and other providers as appropriate. Care teams can be either co-located in one setting or function as a virtual team in multiple sites. Interprofessional care will enable all health professionals to work to their full scope of practice or expertise. This will optimize work place satisfaction for primary care providers, and assist with training, education and recruitment of new primary care providers."

(HNHB LHIN Clinical Services Plan, November 2009)

Goal: Teamwork for Quality Care and Effective Practice

Objectives	Implementation Strategies	Early Actions - Year 1
	Implement patient-directed care	
	Provide people with information and support to enable them to participate in their care delivery	Implement and evaluate an interprofessional care "virtual team" pilot among health care providers
Improve people's ability to make informed decisions	Establish LHIN-wide screening targets	Establish LHIN-wide screening targets
Improve patient care	Implement appropriate, secure, real-time access to patient information for optimal patient care	Develop an Interprofessional Care (IPC) best practice toolkit for dissemination and uptake
Improve provider satisfaction	Optimize health professional practice scope	Sponsor continuing Medical Education events
	Implement appropriate, secure, real-time access to patient information for optimal patient care	Advance uptake of P-Prompt and ClinicalConnect
Connect more people without a family physician to primary care		
Build eHealth infrastructure to support communication and shared information		

Performance Goals

- Patients and their families are part of the care giving team
- Patients are confident in the care giving team's ability to take care of their health care needs
- Health caregivers collaborate and communicate effectively
- Health care settings embrace interprofessional care
- Infrastructure, funding models and policies exist to support interprofessional care.
- Increase number of health professional learners exposed to interdisciplinary, collaborative and team-based models

The imperatives of a ***healthier population*** *and health system sustainability lie with improved access to inter-professional primary care for best outcomes.*

Transportation

...An 'Enabler for Transformation' Priority

> *"Transportation is one of three* ***top key issues*** *for people in the HNHB LHIN when asked: Thinking about the health system, what would you change?"*[32]

About Transportation

For persons without a vehicle of their own or ready access to one, transportation services provide access to health services. Transportation enables people to participate in community life, enhancing their health, well-being and independence. Transportation services are an important support for seniors, other individuals with short or long-term activity limitations, and families with young children.

LHIN-Funded Transportation

HNHB LHIN-funded transportation services make a small contribution, alongside other non-profit services, and specialized municipal services, to people accessing health and social supports. More frequently, people depend on family, friends or accessible transportation programs in their communities, if available.

Among LHIN-funded programs, there is considerable variation in their distribution, eligibility criteria, user fees, and daily/hourly availability. Persons with mobility issues, persons with behavioral challenges and children and youth under the age of 16 are not eligible for many services. There is a lack of affordable regional transit which is a barrier to getting to specialized health services either within or outside a region[33].

Planning for Transportation

Transportation planning and improvement is a shared responsibility. Accessible and affordable transportation promotes people's social and economic inclusion, independence, choice and well-being. Two key considerations for future planning include:

- LHIN residents' taxes support health services, no matter where they are located and they are entitled to these services when needed.
- Alone, no single transportation provider can assure equitable access to "getting around." It is a shared and complementary responsibility.

Looking Ahead

- Integrate transportation with community and service planning for healthy, active living.
- Respecting its community base, grow transportation from its charitable roots to a business model that is accountable for safe, accessible, and efficient transportation.

Goal: Equitable Access to Health Care Services

Objectives	Implementation Strategies	Early Actions - Year 1
Advance equitable access to LHIN-funded transportation programs	Harmonize client eligibility criteria	Link implementation of community-based dialysis stations with local transportation authorities and providers
Optimize community-based transportation resources	Implement business improvement processes for improved sector capacity, effectiveness and efficiency	Integrate transportation access requirements with clinical services planning
	Implement demand modeling tools for proactive capacity building	Integrate transportation funders and planners with local health planning
	Reduce avoidable emergency department visits and hospitalizations	Identify guidelines for transportation programs to be funded in the pending M-SAAs
	Align LHIN funded transportation services with population health and system improvement goals	

Performance Goals

- Improve coordination of transportation within and between LHIN municipalities.
- Equitable access to LHIN-funded transportation services
- Improve client satisfaction

Partners for Change

...An 'Enabler for Transformation' Priority

The HNHB LHIN actively creates synergies through
collaboration with partners *and change agents.*

These are some of the partnerships facilitating learning and innovation in the HNHB LHIN.

Integrated Decision Support Data Warehouse and Business Intelligence Solution

Partner: Hamilton Health Sciences

The Integrated Decision Support (IDS) Data Warehouse and Business Intelligence (BI) Solution is an HNHB LHIN eHealth project, jointly funded by the HNHB LHIN (start-up) and HNHB LHIN hospitals and HNHB CCAC in a cost sharing model. It enables organizations in the LHIN to make evidence based planning and operational decisions using data that are less than three months old. Information is accessed through a secure web-based user-friendly portal. Microsoft Business Intelligence Software applies innovative techniques for accessing, analyzing and reporting data.

Academic Partnerships for Performance Improvement

Partners: McMaster University, Mohawk College

The HNHB LHIN has several partnerships with its universities and colleges that facilitate the implementation of best practices and the training of health human resources. McMaster University, Faculty of Health Sciences and the LHIN are collaborating to develop an evaluative process that will include performance indicators for the IHSP. The faculty are recognized as leaders in the development of clinical pathways and best practice tools, and this expertise will facilitate improved quality of care and access to services across health care providers in the LHIN. Clear partnerships with our colleges and McMaster will maximize the learning experience for all health care trainees and provide a valuable health human resource over the next decade. The HNHB LHIN Physician Lead is a special advisor to the McMaster and Mohawk faculties to develop integration strategies among primary care, community and hospitals.

Best Practice Spotlight Organization

Partner: Registered Nurses Association of Ontario (RNAO)

The HNHB LHIN is one of 16 sites across the province that has the opportunity to work with the RNAO by becoming a Best Practice Spotlight Organization (BPSO). Implementation of RNAO Best Practice Guidelines (BPGs) will be facilitated by sharing resources, and learning from all participating organizations. A Project Coordinator is responsible for bringing organizations together to promote learning, sharing and collaboration among HNHB LHIN health sites. The potential benefits to patients and staff are significant and will be evident when RNAO BPGs are implemented and evaluated across the LHIN during this three-year initiative.

Chronic Disease Prevention and Management Initiative

Partner: Institute for Clinical Evaluative Sciences (ICES)

The HNHB LHIN adopted a CDPM strategy based on the Institute for Health Improvement's (IHI's) Triple Aim approach. The LHIN partnered with ICES to assist the LHIN to identify target populations for this health needs planning approach. ICES is estimating the prevalence of diabetes and COPD among HNHB communities and

assessing co-morbid illness, emergency department use and potential markers of access to or quality of outpatient care among these populations. Subsequently, the LHIN will engage health and wellness providers in the identified communities to assess potential interventions to improve health status, enhance the patient care experience and reduce or control the per capita cost of care.

Continuing Health Sciences Education Event

Partner: McMaster University, primary care providers, public health, academia and clinical experts

The LHIN hosts an annual Continuing Health Sciences Education Event (CHSEE) for health care providers across the LHIN. The objective is to raise awareness of chronic disease prevention and management within the LHIN, demonstrate how evidence-based care can be incorporated into routine practice and promote practical collaborative approaches to CDPM that facilitate seamless transition across care settings.

Community Engagement

Partner: Dr. Julia Abelson. Director, Centre for Health Economics and Policy Analysis, McMaster University.

The LHIN is one of five decision-making partners in a research initiative: Evaluating the Impacts of Public Engagement in Health Systems: A comparative Research Practice Collaboration (Julia Abelson, Principal Investigator). The initiative will explore how learnings from a predecessor study have shaped organizations' engagement knowledge, values and practices, and decision making for which it is intended to inform. The benefits of the partner initiative to the HNHB LHIN and by extension other LHINs is how to build, sustain and improve purposeful public engagement capacity.

Physician Engagement

Partner: Ontario College of Family Physicians

The Ontario College of Family Physicians co-sponsored with the LHIN a series of primary care engagement sessions. The goal was to integrate a primary care perspective in the development of the LHIN's Clinical Services Plan. The ongoing partnership is creating innovative continuing education opportunities and *Main Pro, Continuing Medical Education* credits.

Clinical Services Plan

The HNHB LHIN Clinical Services Plan (November 2009) was a significant building block for this IHSP. The key directions for health system improvement – interprofessional care, integrated clinical programs and community-based health service capacity have been integrated with the IHSP. The HNHB LHIN Clinical Services Plan is available at www.hnhblhin.on.ca.

Open House, Hagersville United Church, Hagersville, October 15, 2009

Rationale for Strategic Directions

a health care system that helps keep people healthy, gets them ***good care*** *when they are sick, and will be there for our children and grandchildren.*

Consistent with other LHINs the HNHB LHIN adopted a decision-making framework. The framework assists the LHIN and others, to plan, deliberate and arrive at decisions that are made on the basis of reasons and that are transparent.

HNHB LHIN Decision-Making Framework

Domain	Criteria	Definition / Description
Strategic Fit	Alignment with IHSP	Degree of impact.
	Alignment with provider system role	Extent to which program/initiative is consistent with the provider(s) mandate and capacity compared to other providers in Ontario or the local health system and priorities.
Population Health	Health Status	Impact on clinical outcomes for the patient/client, including risk of adverse events, and/or impact on physical, mental or social quality of life, as compared to current practical service.
	Prevalence	Magnitude of the disease/condition that will be directly impacted by the program/initiative as measured by prevalence (i.e. number of individuals with the condition in the population at a given point in time).
	Health promotion & disease prevention	Impact on illness and/or injury prevention and promotion of health and well-being as measured by projected longer term improvements in health and/or likelihood of downstream service utilization reduction.
System Performance	Access	Extent to which program/initiative improves timely access to appropriate level of health services for defined population(s) in the local health system.
	Quality	Extent to which program/initiative improves safety, effectiveness, and client experience of health service(s) provided.
	Sustainability	Impact on clinical, financial and human resources capacity over time.
	Integration	Extent to which program/initiative improves coordination of health service providers to ensure continuity of care in the local health system and provision of care in the most appropriate setting as determined by patient/client's needs.

Domain	Criteria	Definition / Description
System Values	Client-focus	Extent to which program/initiative meets the health needs of a defined population and the degree to which patients/clients have a say in the type and delivery of care (i.e. is the service client centred?)
	Partnerships	Degree to which appropriate level of partnership and/or appropriateness of partnerships will be achieved in order to ensure service quality enhancement, optimal resource use, minimal duplication, and/or increased coordination.
	Community Engagement	Level of involvement of target population and other key stakeholders in defining the project as well as planned involvement in evaluation, with the expectation that this will impact aspects of population health and key system performance
	Innovation	Impact on generation, transfer, and/or application of new knowledge to solve health or health system problems: evidence of evaluation plan and application of leading practices.
	Equity	Impact on the health status and/or access to service of recognized sub-populations, where there is a known health status gap between this specific population and the general population as compared to current practice/service.
Readiness	Efficiency (operational)	Extent to which program/initiative contributes to efficient utilization of clinical, financial, and human resources capacity to optimize health and other benefits within the system.
	LHIN Capacity	Does the LHIN have the needed material, financial, and health human resources to support this project at this time? If the project is sufficiently important, are there ways to leverage system resources to make the project viable now or in the future?
	Interdependency	Does the project depend on completion of other projects? Are other high priority projects depending on the completion of the proposed project? Is this project aligned with other projects that would need also to be funded in order for them to be viable?
	Risk	Is the level of risk involved acceptable? Have mitigation strategies been identified to address this risk and are they practical? What are the risks of funding or not funding or endorsing the project at this time?
	Health System Impact	Does this project raise any considerations of health system impact that were not addressed in the evaluation process? What impact would funding the project have on other fundable projects in terms of material, financial, and human resource?

Decision criteria are used to assess and rank options, explain LHIN decisions to stakeholders and ensure a consistent rationale for LHIN decisions.

Measuring Success

Balanced Scorecard

The HNHB LHIN Balanced Scorecard reports performance information across four domains that are the cornerstones of the LHIN's mission and vision.

The scorecard captures information that the LHIN provides to the ministry as part of its quarterly report. The data provided is obtained from a variety of information systems and is the most recent available for inclusion in the Scorecard. Most of the information reported in the HNHB LHIN scorecard is 3-6 months old.

As the LHIN continues to produce the scorecard each quarter, indicators may change, based on their usefulness and the availability of data.

The Scorecard is available in more detail on the HNHB LHIN website: www.hnhblhin.on.ca.

System Integration

System integration focuses on measures that report how well the system is integrating (connecting) care as clients access various services within the health care system.

Examples of Key Indicators

- Percent of ALC days
- Median time to LTC placement (days)
- Acute clients who receive their first home care visit within three days from referral date
- Hospital Standardized Mortality Rate, i.e. the ratio of actual in-hospital deaths compared to expected
- Hospital - Patient Satisfaction - Overall Impression
- Number of hospital emergency department unscheduled visits per 1000 population
- Hospitalization rate for ambulatory care sensitive conditions, i.e. hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to hospital
- Number of avoided hospital admissions through ED by referral to CCAC

Financial Health and System Sustainability

Financial health and system sustainability focus on measures that report how well the health care organizations are managing health care resources in a fiscally prudent manner.

Examples of Key Indicators

- Total Margin (a comparision of total revenues to total expenses) - Number of hospitals report total margin greater than zero
- Hospital Current Ratio (a comparison of current assets to current liabilities) - Number of hospitals within performance corridor of 0.8-2
- Percent of community providers that meet service volume targets outlined in M-SAA
- Change in hospital productivity
- Community Service Agencies - total margin

Client Access and Outcomes

Client Access and Outcomes focuses on measures that report clients' abilities to get health care services in a timely manner.

Examples of Key Indicators

The following wait times are measured from the time a surgery/test is orderered to the time it is delivered:

- Cancer surgery wait times
- Cataract surgery wait times
- CT scan wait times
- Diagnostic MRI scan wait times
- Knee replacement wait times
- Hip replacement wait times
- Cardiac bypass surgery wait times

The following wait times measure total time spent in the ED, depending upon severity of the problem and whether a patient is admitted:

- Percent of ED admitted patients treated within the LOS target of less than or equal to eight hours

- Percent of ED non-admitted high acuity patients treated within less than 8 hours for CTAS I-II and less than 6 hours for CTAS III
- Percent of ED non-admitted low acuity patients treated within less 4 hours for CTAS IV and V

Other indicators:

- Community Services - Wait time from hospital referral to assessment
- Percent of chronic stay patients in complex continuing care with new Stage 2 or greater, skin ulcers

Organizational Health

Organizational health focuses on measures that report how well the health care organization is managing its heath human resources.

Examples of Key Indicators

- Number of hospitals that have at least 70% of their nurses employed full time (+/- 3%)
- Hospital percent Sick Time - Number of hospitals below the provincial 90th percentile of 4.8%
- Hospital percent Overtime - Number of hospitals below the provincial 90th percentile of 2.6%
- Community Agencies – Operational variance between budget and forecast, i.e. achieving a balanced budget
- Community Agencies – Statistical variance between budget and forecast units of service, i.e. meeting expected service delivery numbers

Definitions:

ALC - When a person is in a bed in a hospital and does not require hospital care they are called 'Alternate Level of Care" as they are waiting for a different level of care.

Hospital Standardized Mortality Rate - A ratio that compares the actual acute in-hospital deaths to the expected number of in-hospital deaths, adjusted for local demographics, e.g. age, sex.

Hospitalization Rate for Ambulatory Care Sensitive Conditions - The rate of people admitted to hospital that could be treated as an out-patient.

ED - Emergency Department

Acute Myocardial Infarction (AMI) - The clinical term for a heart attack.

Total Margin - The % by which total revenues exceed or fall short of total expenses.

Hospital Current Ratio - Current assets divided by current liabilities.

MSAA - Multi-Sector Service Accountability Agreements.

LOS - length of stay.

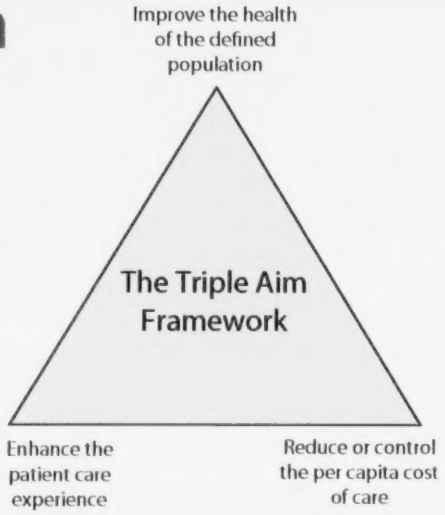
CTAS I –II & CTAS IV –V - The classification system used is the Canadian Triage and Acuity Scale referred to as CTAS: Patients are categorized as:

Level 1 = resuscitate
Level 2 = emergent
Level 3 = urgent
Level 4 = less urgent
Level 5 = non urgent

Commitment to Action

Triple Aim: Health, Care, and Cost

LHINS are working together to learn and apply an approach to implementing improved models for providing health care. The Triple Aim approach has three intentional goals: improve the health of a defined population, enhance the patient care experience, and reduce or control the per capita cost of care. This approach is being used to improve models for chronic disease prevention and management, specifically in the areas of diabetes and COPD.


Improve the health of the defined population
The Triple Aim Framework
Enhance the patient care experience
Reduce or control the per capita cost of care

The LHIN - Triple AIM "Fit"

Looking ahead to the implementation of the IHSP, commitments are required:

- Continue to place patients and families at the forefront of system design. Define quality from the perspective of the patient experience of a defined population (for example, diabetics with a mental illness).
- Introduce story telling as a key focus of community engagement.
- Use client experiences and stories to advance integration and quality improvement.
- Increase the LHIN's role as an integrator, linking organizations across the continuum and facilitating collaboration among health services to work as a system for the defined population.
- Continue to engage active partnerships with other health care and non-health care sectors to improve health, build capacity for self management, and reduce prevalence of disease.
- Focus integration dialogue on common interests, and practical coalitions, respect diversity of health providers and social services to achieve shared aims, and create sustainable impact on health.
- Identify savings for reinvestment in health care improvements. Create the best outcomes with the least cost.

LHIN Objectives

Strategic

System Level Aims (IHSP)

Operational

Community Engagement

Integration/System Design

Performance Management

Tactical

Change Management/Execution

Foci of the Triple AIM

A focus on individuals and families

Redesign of primary care services and structures

Population health management

A cost-control platform

System integration and execution

Coalition building with other sectors

Supporting Documents

All of the following documents are available on our website - www.hnhblhin.on.ca

- Our Commitment to You, Appendix A from the Integrated Health Service Plan 2006-2009
- Soaring Vision: Aboriginal Health Search Conference, March 2008
- Let's Talk: Aging at Home - Listening and Learning about Healthy Aging and Independent Living, A Report to the Community, July 2008
- Chronic Disease Prevention and Management - Diabetes Action Group Report, December 2008
- Clinical Services Plan Final Report, November 2009
- Preliminary Findings: HNHB LHIN Transportation Survey, November 2009
- HNHB LHIN Health Atlas, December 2009

End Notes

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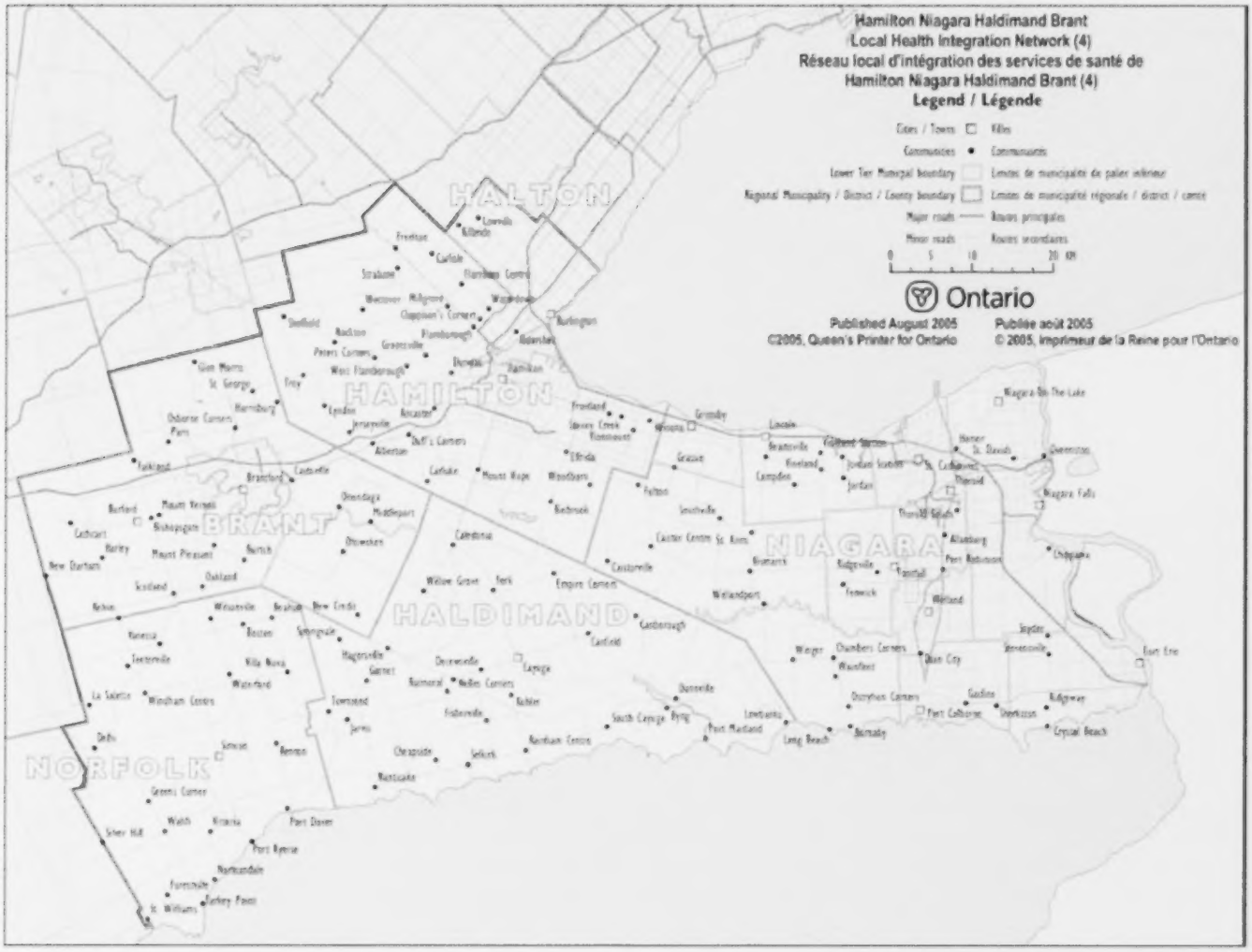

Contact Us

Telephone: (905) 945-4930
1 (866) 363-5446
Fax: (905) 945-1992
Email: hamiltonniagarahaldimandbrant@lhins.on.ca
Address: 264 Main Street East
Grimsby, ON L3M 1P8
Website: www.hnhblhin.on.ca

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Réseau local d'intégration des services de santé